BEFORE THE
FEDERAL COMMUNICATIONS COMMISSION
WASHINGTON, D.C. 20554

In the Matter of Rural Health Care Support Mechanism	)	WC Docket No. 02-60

COMMENT OF
DR. AARON WILSON, JR., COMMISSIONER
PENNSYLVANIA PUBLIC UTILITY COMMISSION

Pursuant to Sections 1.49, 1.415, and 1.419 of the Federal Communications Commission's ("FCC" or "Commission") Rules of Practice and Procedure, 47 C.F.R. §§ 1.49, 1.415, and 1.419 (1997), Dr. Aaron Wilson, Jr., Commissioner of the Pennsylvania Public Utility Commission (Commissioner Wilson) submits this Reply Comment (Reply Comment or Comment) as the Reply Comment of Commissioner Aaron Wilson. My Reply Comment addresses several issues raised in the FCC's Notice of Proposed Rulemaking issued on April 19, 2002 in the above-captioned matter.[1]

The FCC notice seeks comment on (1) discounts for Internet access by eligible rural health care providers; (2) expanding the number of entities eligible for discounts by changing the definition of "urban area" and the definition of eligible entities; (3) other proposals that could change how those

[1]Much of the statistical information in this comment is publicly available at the website of the Center for Rural Pennsylvania, a bipartisan and bicameral agency of Pennsylvania's General Assembly. Act ;67, 1987 PL 163. Information on rural Pennsylvania can be obtained from their website, www.ruralpa.org. Citation to Center for Rural Pennsylvania statistics should not be construed as the Center's endorsement of the statements supported by their statistics.

discounts are calculated; (4) how to address financial support of rural health care providers if demands exceed the annual cap of $400 million; and (5) efforts to avoid waste, fraud, and abuse.[2]

The five areas addressed by the Rural NOPR are a result of several considerations including, but not limited to, the fact that the rural health care support mechanism is greatly underutilized.[3] The FCC is concerned about the fact that only 700 rural health care providers out of nearly 8,300 received support in Funding Year 3 from the $400 million currently dedicated to rural health care support.[4]

I commend the FCC for their recognition of this concern. I am also aware of the fact that approximately $10.8 million of the annual $400 million funding was allocated for Fiscal Year 2000 and that approximately $16.9 million of the same $400 million annual funding limit was allocated in Fiscal Year 2001. Pennsylvania, a commonwealth with one of the largest number of rural residents, received an average of $5,422 per year during the past four years in which rural health care providers could apply for support.[5]

Consequently, I share the FCC's concern that this fund is greatly underutilized. This underutilization has a direct and negative impact on Pennsylvania's rural citizens and health care providers.[6] Pennsylvania's rural citizens and health care providers, along with similarly situated citizens

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[2]In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60, Notice of Proposed Rulemaking, Released April 19, 2002, Paragraphs 87-88 (Rural NOPR). The FCC proposes to take action based on the Telecommunications Act of 1996, Pub. L. No. 104-104, 110 Stat. 56 (1996) (codified at 47 U.S.C. §§ 151 *et. seq*.) ("1996 Act" or "Act").
[3]Rural NOPR, Paragraph 10.
[4]Ibid., Paragraph 10.
[5]See http://www.universalservice.org.
[6]The impact cannot be overstated. Pennsylvania's rural population densities range from 11.4 persons per square in Forest County to 331.85 in rural Lebanon County while Philadelphia's county has 10,639.35 per square mile. Moreover, rural Pennsylvania has 162 doctors per 100,000 population compared to 385 doctors per 100,000 in urban Pennsylvania. Rural Pennsylvania has a total of 56 general acute care hospitals compared to 140 for urban Pennsylvania. Median income in rural

and health care providers in other states, are not effectively accessing this rural health care support funding mechanism.

I welcome the opportunity to file this Reply Comment on behalf of Pennsylvania's rural citizens. That opportunity is particularly appreciated in view of the fact that the concerns expressed herein are supported by public-domain information on Pennsylvania's rural areas.

The Reply Comment focuses on the FCC's issues as they pertain to Pennsylvania specifically and the national program generally. As a preliminary matter, I note that the urban classification commonly given to Pennsylvania stems from the fact that Pennsylvania has multiple cities of international, national, or regional stature within its borders. This urban and industrial label, however, obscures the fact that Pennsylvania has significant rural areas that share many of the demographic, social, and economic challenges as our core urban areas.[7]

Pennsylvania, which ranges from $27,451 in Fayette county to a high of $46,257 in Monroe county, must not obscure the fact that the per capita income in rural Pennsylvania is $7,800 below our urban areas and $6,100 below the national average. Moreover, this gap has widened in the last 30 years to the point that the gap between Pennsylvania's rural per capita income and urban Pennsylvania has more than doubled since 1970. Center for Rural Pennsylvania, *Profile of Rural Pennsylvania (March 2002),* p. 2.

[7]For example, Pennsylvania's urban counties averaged 30,556 building permits at an average cost of $116,321 while our rural counties averaged 10,520 building permits at an average cost of $100,639. Also, 10.8% of rural Pennsylvanians live in poverty compared to 10.4% of urban Pennsylvania. Participation in Pennsylvania's Pharmaceutical Assistance Contract for the Elderly (PACE), an entitlement program based on age and income, has an 18.5% participation rate in rural Pennsylvania compared to a 13.1% rate in urban Pennsylvania. Moreover, 9.2% of rural Pennsylvanians required homeless assistance programs compared to 9.4% of urban Pennsylvanians. Given the important role that the school lunch program plays in the Schools & Libraries program, it is worthwhile noting that 30.9% of rural Pennsylvanians in public schools participate in that program compared to 32.4% of urban Pennsylvanians. Finally, enrollment in Pennsylvania's Children Health Insurance Program, a health insurance and medical services assistance program for families based on their income, enrolls 4.6% of rural Pennsylvania children compared to 3.7% of urban Pennsylvania children. From a public health perspective, the rural birth rate is lower compared to urban birth rates (10.9 births per 1000 compared to 12.1 per 1000) and its death rates are higher (10.7 per 1000 compared to 10.6). In fact, the death rates attributed to heart disease (3.51% for rural Pennsylvania compared to 3.25% for urban Pennsylvania), stroke (.75 rural vs. .72 urban), chronic lower respiratory diseases (.53 compared to .48), and unintentional injuries resulting in death (.37 compared to .36) are *higher in rural Pennsylvania compared to urban Pennsylvania.*

Reply Comment

As an initial matter, the FCC should realize that Pennsylvania is an urban state with substantial rural areas that are not using the FCC's health care support mechanisms. The fact that Pennsylvania, and the nation generally, is not availing itself of these resources indicates the need to develop a national and state program to educate rural areas and their service providers about the existence of this support.

Second, some of Pennsylvania's rural areas are simply unable to access that support because of the FCC's rigid reliance on an older Office of Management and Budget (OMB) definition of urban and rural areas. This rigidity is particularly disturbing because the OMB's most recent definition is even more restrictive and should not be used for funding purposes.[8] This dilemma can be corrected by a rules revision that allows interested states to petition to receive a waiver, for good cause shown and with adequate evidence, needed to avail themselves of the rural health care support mechanism.[9]

Definitions. The FCC should not use the OMB's new definition as the benchmark for rural funding for several reasons. First, the OMB has stated that its Metropolitan and Micropolitan areas are *not* designated as a general purpose geographic framework for non-statistical activities ***or for use in***

[8]In December 2000, the OMB created three new population categories. These are (a) Metropolitan; (b) Micropolitan; and (c) Areas Outside Core Based Statistical Areas. None of these terms uses the term rural even though significant parts of Pennsylvania and the nation are, and remain, rural in character.

[9]The rule should require submission of evidence on (1) population densities in the petitioning area compared to a state's most urban area; (2) median household income in the petitioning area compared to median income in the state's urban area; (3) poverty rates in the petitioning area compared to the state's urban area; (4) demographic, natality, and mortality rate comparisons in a petitioning area compared to the state's urban area; (5) health care provider evidence on (a) physicians per population in the petitioning area compared to the state's most urban area; (b) the total number of hospitals in the petitioning area compared to the state's most urban area; and (c) the total number of hospital beds in the petitioning area compared to the state's most urban area; and (6) costs to provide internet access and advanced telemedicine services in the petitioning area compared to the state's most urban area.

program funding purposes.[10] Any use of OMB definitions for rural health care funding support runs afoul of the OMB's requirements and could be grounds for challenging the FCC's regulations as a violation of Section 254(h) of the Telecommunications Act of 1996.[11] Second, the FCC's current definitions may retain their apparent validity and, whatever their weaknesses, are probably better than the newly minted OMB definitions. However, the FCC's rules on definitions should be amended to permit a state to submit a petition for a waiver, to remove the exclusion of such areas from funding, if the state concludes that the FCC's definitions or results exclude their rural counties or areas funding from the rural health care support mechanism. The wisdom of that approach is underscored by the fund's underutilization at the present time.

Discounts. The FCC should adhere to the Section 254(h)(7)(B) criteria. However, the interpretation of what is permitted under Section 254(h)(7)(B)(vii) could be expanded to permit funding for private entities that are willing to undertake or perform the functions specified in (h)(7)(B)(i) through (vi). The scope of eligible providers should include nursing homes or any joint venture of private and public health care providers *only* to the extent they perform documented Section 254(h)(7)(B)(i) through (vi) functions. The scope of what qualifies for funding should be expanded to include educating technicians and employees on the use of the advanced services funded by the rural health support mechanism. This will facilitate the diffusion of knowledge on advanced services

[10] 65 FR 82228; 65 FR 82236, emphasis added.

[11] That issue could arise if a state or aggrieved party claims that the FCC's denial of rural health care funding is premised on an unsustainable conclusion that a rural area or county is urban based on a definition that, on closer scrutiny, is effectively denying counties or regions of the country access to rural health support. The violation occurs when a rural area or county's citizens cannot access, or health care providers cannot deliver, health care services on terms reasonably comparable to urban

for the delivery of health care services on terms comparable to those in urban areas. This comports with Section 254(h).

Eligibility. The FCC could expand the definition of "telecommunications carriers" under Section 254(h)(1)(A) of the act to include Internet Service Providers (ISPs) for purposes of funding under Section 254 regardless of the technology deployed *so long as the technology deployed is open to ISPs not associated with the technology provider unless it can be shown that such a requirement is impractical or not economically feasible.*[12] The FCC should avoid invoking Section 254(h)(2)(A) because it is premised on an as-yet-to-be-determined interpretation of the FCC's Internet authority under its "advanced telecommunications and information services" theory for Internet access. If, however, the FCC chooses to rely on Section 254(h)(2)(A) in light of the court's decision in *Texas Office of Public Utility Council,* 183 F.3d at 443-44, the FCC must stress that these non-telecommunications carriers are operating as telecommunications carriers under Section 254(h)(1)(B) for purposes of providing rural health care services. That way, the technology and network provider is being supported as a supplier of telecommunications services for the express purpose of ensuring that rural health care providers gain access to the Internet for telemedicine purposes.

For all applicants, the FCC should use the health care provider's prior year's cost to access the internet, at speeds needed to provide telemedicine comparable to those in use in urban areas, for Section

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areas. Such a violation would be particularly compounded by a rigid reliance of a definition that the defining agency expressly stated was not to be used for funding purposes.

[12] For example, a rural health care provider may choose to provide telecommunications services through a variety of technologies i.e., wireline, wireless, satellite, cable, or fiber from an electric or gas affiliate's operation. The health care provider's funding will be provided so long as the technologies and the networks chosen also allow unaffiliated ISPs to operate on the chosen network unless, of course, such a requirement is not economically feasible.

254(h)(7)(B) purposes. The benchmark measure for funding the discount should be the difference in cost between providing comparable technology and network services in a rural area and the lowest rate in (a) a general hospital in the closest city of 50,000; (b) a preferred university research hospital; or (c) any one of no more than two primary urban centers.[13]

The FCC cannot summarily conclude that toll charges to access the Internet are no longer an issue in rural areas nor should that funding category be eliminated in any future rulemaking. The FCC could only do that by relying on the absence of requests for toll service support. However, the two-year period referenced in the Rural NOPR occurred during a period in which the FCC recognizes that its program was greatly underutilized. Without knowing precisely *why* so few requests were received, I would caution against making the assumption that the reason is because toll charges not an issue. Just as possible, the reason could be because the cost and time required to complete the required forms may outweigh the benefits received from the discount. Moreover, any relative plethora of toll-free internet access providers at the current time may well be negatively impacted by recent economic and investment developments in the telecommunications sector of the economy.

[13]For example, Verizon Pennsylvania's advanced services are tariffed by Density Cells (based on the number of access lines a consumer can access) and mileage. There are four density cells ranging from Density Cell 1 (Philadelphia Center), Density Cell 2 (Suburban Philadelphia), More Rural Areas such as Harrisburg (Density Cell 3) and Clearly Rural Areas such as the Northern Tier or parts of Central Pennsylvania (Density Cell 4). Verizon's current rates for Pricing High Capacity Service (1.544 Mbps) ranges from $210 per termination in Density Cell 1 to $270 per termination in Density Cell 4. Rates for High Capacity Service for 44.736 Mpbs/Lightwave under its Volume Term Pricing Plan #1 range from $205 monthly in Density Cell 1 for a two year rate compared to $264.60 per month in Density Cell 4. Although by no means exhaustive, they illustrate the importance of funding support based on a density-cell basis compared to a locational basis. Moreover, the full full range of pricing and services under Verizon Pennsylvania's tariffs is publicly available at http://retailgateway.bdi.gte.com:1490/cyberdocs.asp?optState=Pa&branch=Y.

Finally, the FCC should endorse joint efforts with schools and libraries. However, support should be given *only to the extent that Section 254(h)(7)(B) functions are or will be performed.* Joint efforts should not be a device whereby the funds in the underutilized rural health care support program are transferred to the oversubscribed schools and libraries program. That program should directly address any problems with oversubscription in the schools and libraries program.

Other Proposals. The FCC's rules should permit petitions for a waiver from states seeking to secure rural health care support for areas that may not currently qualify under the FCC's current definitions. Continuation of the current definitional categories, whatever their weaknesses, is far better than adopting a new OMB definition that the OMB does not want used for funding purposes. The evidentiary criteria for such petitions should require evidence on the rural area or county's (1) population density; (2) Median Household Income; (3) Poverty Rate; (4) Demographics; (5) Physicians per household; and (5) Hospitals per population compared to a benchmark urban county in that state.

Second, the FCC should develop a simple record-keeping requirement for joint public-private health care providers so that services provided under Section 254(h)(7)(B) can be demonstrated and audited for veracity. There could even be a limit on rural health care support in joint ventures. For example, cost for joint venture arrangements could be limited to 75% of total cost compared to 100% of total cost for more clearly eligible service providers.

Allocations if Demand Exceeds Supply. The FCC should retain its pro-rata approach in the event the current $400 million cap is exceeded. This is a workable approach that, to date, has yet to be invoked. There is no need to correct an approach that has yet to be put to the test.

Fraud Prevention. The record-keeping requirements set forth above, as well as confirmation from a chosen technology and network service provider that unaffiliated ISPs are permitted to bid for the health care providers needs, should be the absolute minimum requirements in order to prevent fraud, waste, and abuse of federal resources. Finally, the FCC could require a health care provider seeking federal rural support to competitively bid for services from all available technology and network providers consistent with the criteria set forth above.

Conclusion

I commend the Federal Communications Commission for recognizing and addressing the underutilization of the rural health care support mechanism. I especially appreciate the opportunity to submit these comments in order to make a good idea become reality in the lives of Pennsylvania's rural citizens and their health care providers. I urge the FCC to consider, and adopt, the recommendations set forth in this Reply Comment in order to produce a direct result of this state-federal undertaking.

Respectfully submitted,

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